The Department of Public Health’s (DPH) Prescription Drug Monitoring Program (PMP) serves as a repository of data for all prescription drugs dispensed statewide, including those prescriptions that are sought after for illicit and non-medical use and thus represent the highest potential for abuse (federal Schedules II – V, including certain narcotics, stimulants and sedatives). The PMP also enables prescribers and dispensers to access a patient’s prescription history and can be used as a clinical decision-making tool, allowing the provider to have a holistic view of the patient’s medications.

When interpreting PMP county-level data, it is important to emphasize that increases or decreases in a single measure may not indicate an increase or decrease in prescription misuse or abuse. Put simply, use does not always equate to abuse. There are many factors that might explain an unusually high rate of prescribing in a given area. For instance, an area which contains a large number of residents in long-term care facilities may result a high rate of opioid prescribing.

These datasets inform critical discussions about opioid prescribing, provide an important baseline to better inform future policy decisions and allow the state and stakeholders to more meaningfully measure whether policy initiatives are effective.

Effective October 6, 2014, all hydrocodone combination drug (HCD) products (e.g., Vicodin) were reclassified from Schedule III to Schedule II. This reclassification during the last quarter of 2014 makes comparisons over time difficult to interpret. Beginning with CY 2015 data, reports of Schedule II products will include all HCD prescriptions.

Individuals with activity of concern "thresholds" for this report are based on a 3-month time period. MDPH also releases an annual county-level report that provides thresholds that are based on a 12-month time period. Although the numbers (or rates) generated may appear to be comparable, they represent different time periods and are NOT an apples-to-apples comparison. The results are only comparable when the thresholds (e.g., 4 different providers and 4 different pharmacies), time interval (e.g. over a three-month period), and drug products analyzed (e.g. Schedule II opioids) are the same. Meaning, the total number (or rates) of individuals who received Schedule II-V opioid prescriptions from 4 or more providers and had them filled at 4 or more pharmacies in a 3-month period cannot and should not be compared with the total number of individuals (or rates) who received Schedule II-V opioid prescriptions from 4 or more providers and had them filled at 4 or more pharmacies in a 12-month period.
<table>
<thead>
<tr>
<th>County</th>
<th>Census Population</th>
<th>Total Schedule II Opioid Prescriptions</th>
<th>Total Number of Schedule II Opioid Solid Dosage Units</th>
<th>Individuals Receiving Schedule II Opioid Prescription</th>
<th>% of Individuals Receiving Schedule II Opioid Prescription (of total population)</th>
<th>Individuals with Activity of Concern</th>
<th>Rate of Individuals with Activity of Concern (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstable</td>
<td>214,333</td>
<td>27,218</td>
<td>1,536,712</td>
<td>12,287</td>
<td>5.7</td>
<td>22</td>
<td>1.8</td>
</tr>
<tr>
<td>Berkshire</td>
<td>127,828</td>
<td>15,636</td>
<td>854,705</td>
<td>6,939</td>
<td>5.4</td>
<td>&lt; 5</td>
<td>NR</td>
</tr>
<tr>
<td>Bristol</td>
<td>556,772</td>
<td>77,478</td>
<td>4,684,046</td>
<td>33,443</td>
<td>6.0</td>
<td>36</td>
<td>1.1</td>
</tr>
<tr>
<td>Dukes</td>
<td>17,299</td>
<td>2,025</td>
<td>119,207</td>
<td>1,006</td>
<td>5.8</td>
<td>&lt; 5</td>
<td>NR</td>
</tr>
<tr>
<td>Essex</td>
<td>776,043</td>
<td>76,861</td>
<td>4,213,600</td>
<td>36,029</td>
<td>4.6</td>
<td>37</td>
<td>1.0</td>
</tr>
<tr>
<td>Franklin</td>
<td>70,601</td>
<td>10,060</td>
<td>616,896</td>
<td>4,171</td>
<td>5.9</td>
<td>&lt; 5</td>
<td>NR</td>
</tr>
<tr>
<td>Hampden</td>
<td>470,690</td>
<td>64,414</td>
<td>3,843,894</td>
<td>27,835</td>
<td>5.9</td>
<td>23</td>
<td>0.8</td>
</tr>
<tr>
<td>Hampshire</td>
<td>161,292</td>
<td>18,116</td>
<td>1,153,870</td>
<td>7,414</td>
<td>4.6</td>
<td>7</td>
<td>0.9</td>
</tr>
<tr>
<td>Middlesex</td>
<td>1,585,139</td>
<td>108,421</td>
<td>5,899,860</td>
<td>55,037</td>
<td>3.5</td>
<td>40</td>
<td>0.7</td>
</tr>
<tr>
<td>Nantucket</td>
<td>10,925</td>
<td>1,011</td>
<td>42,862</td>
<td>514</td>
<td>4.7</td>
<td>&lt; 5</td>
<td>NR</td>
</tr>
<tr>
<td>Norfolk</td>
<td>696,023</td>
<td>59,045</td>
<td>3,360,305</td>
<td>28,865</td>
<td>4.1</td>
<td>26</td>
<td>0.9</td>
</tr>
<tr>
<td>Plymouth</td>
<td>510,393</td>
<td>58,931</td>
<td>3,480,974</td>
<td>27,574</td>
<td>5.4</td>
<td>30</td>
<td>1.1</td>
</tr>
<tr>
<td>Suffolk</td>
<td>778,121</td>
<td>52,701</td>
<td>3,156,518</td>
<td>25,424</td>
<td>3.3</td>
<td>28</td>
<td>1.1</td>
</tr>
<tr>
<td>Worcester</td>
<td>818,963</td>
<td>89,638</td>
<td>5,756,634</td>
<td>40,684</td>
<td>5.0</td>
<td>48</td>
<td>1.2</td>
</tr>
<tr>
<td>MA</td>
<td>6,794,422</td>
<td>661,555</td>
<td>38,720,082</td>
<td>307,222</td>
<td>4.5</td>
<td>303</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Note 1: Individuals with activity of concern "thresholds" for this report are based ONLY on a 3-month time period; see notes on previous page; CY16-Q3
Note 2: Counts greater than 0 but less than or equal to 5 are not reported. Rates based on these small values also are not reported (NR).
Note 3: Rates of individuals with activity of concern are based on the population of individuals who have received one or more Schedule II opioid prescriptions during the specified time period.
Note 4: PMP data are preliminary and subject to updates. The MA PMP database is continuously updated to allow for prescription record correction data submitted by pharmacies. This data were extracted on 10/12/2016; Release Date: November 2016.
Note 5: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2010-July 1, 2015, by year, county, single-year of age (0, 1, 2, ..., 85 years and over), bridged race, Hispanic origin, and sex (Vintage 2015).